URI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

EILED VS SEP 26 1960 — Registration District No. 098 — Primary Registration District No. 4165 — Registrar's No. 87

-60-034283 STATE FILE NUMBER

NDED

1. PLACE OF DEATH
a. COUNTY: Daviess
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: Gallatin
Length of stay in 1b: 4 Days
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: Sullivan Rest Home
Inside Limits: Yes [X] No [ ]

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Missouri b. COUNTY: Daviess
c. CITY OR TOWN: Coffey
Inside Limits: Yes [X] No [ ]
d. STREET ADDRESS (If outside, give location): ---
Reside on Farm: Yes [ ] No [X]

3. NAME OF DECEASED (Type or print): First: Zoola Middle: May Last: Mote
4. DATE OF DEATH: Month: September Day: 11 Year: 1960
5. SEX: Female
6. COLOR OR RACE: White
7. Married [X] Never Married [ ] Widowed [ ] Divorced [ ]
8. DATE OF BIRTH: 5-10-1901
9. AGE (last birthday): 59
IF UNDER 1 YEAR: Months: Days: IF UNDER 24 HR: Hours: Min.:
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (City and state or country): Harrison Co. Mo.
12. CITIZEN OF WHAT COUNTRY: USA
13a. FATHER'S NAME: Moses Brown
13b. MOTHER'S MAIDEN NAME: Mary Jane DeWitt
14. NAME OF HUSBAND OR WIFE: John Mote
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No ---
16. SOCIAL SECURITY NO.: NOne
17. INFORMANT Address: John Mote, Coffey, Mo.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Carcinoma Larynx — INTERVAL BETWEEN ONSET AND DEATH: 1 yr.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b): Acute Ascending Paralysis — 2 wks
DUE TO (c):
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)
PART III. If deceased was female was there a pregnancy in last 90 days. [ ] Yes [ ] No [ ] Unknown

19. WAS AUTOPSY PERFORMED? YES [ ] NO [ ]
20a. ACCIDENT [ ] SUICIDE [ ] HOMICIDE [ ]
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. I attended the deceased from Aug. 28, 1960 to 9-11-60 and last saw her/him alive on 9-10-60
Death occurred at 9 P.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): Floyd E. Nelson MD
22b. ADDRESS: Gallatin Mo.
22c. DATE SIGNED: 9-12-60

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE: 9-13-1960
23c. NAME OF CEMETERY OR CREMATORY: Masonic Cemetery
23d. LOCATION (City, town, or county) (State): Gilman City, Mo.

24. FUNERAL DIRECTOR: K. E. Dickerson ADDRESS: Hope Funeral Home, Gallatin, Mo.
25. DATE RECD. BY LOCAL REG.: 9-22-1960
26. REGISTRAR'S SIGNATURE: Virgil M. Engelhart

(Licensed Embalmer's Statement on Reverse Side)

BY AFFIDAVIT OF DOCUMENT

OCT 10 1960

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by

or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed E. O. Dickerson

Licensed Embalmer No. 3302

P. O. Address Gallatin

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to com
with the above constitutes grounds for revocation of license).
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.